STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 21, 22, 23, 24, 2012 Facility number: 000140 Provider number: 155235 AIM number: 100266960 Survey team: Tim Long, RN, TC Julie Wagoner, RN Christine Fodrea, RN Census bed type: SNF: 15 SNF/NF: 106 Total: 121 Census payor type: Medicare: 16 Medicaid: 74 Other: 31 Total: 121 Sample: 24 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/1/12 by Jennie Bartelt, RN.	F0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during our Annual Health Survey conducted on May 21, 2012 at Miller's Merry Manor in Logansport. Hopefully, you will find that the remedies are both sufficient and thoroughly explained in providing you with a clear picture of how we corrected these concerns. I would like to formally request your consideration for granting this facility paper compliance. If, after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at 574-722-4006. Terrence Jent, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) Based on record review and interview, the facility failed to ensure an admission Minimum Data Set (MDS) assessment was completed timely for 1 of 5 newly admitted residents reviewed in a sample of 24. (Resident #4) Finding includes: Review of the electronic clinical record for Resident #4, on 05/22/12 at 10:00 A.M. indicated she was admitted to the facility on 05/07/12. In the MDS assessment portion of the electronic clinical record an initial and a 5 day Medicare MDS assessment was due to have been completed on 05/14/12. The electronic record indicated the assessment was "pending." Review of the assessment indicated the assessment was incomplete as sections on cognition, mood, behavior, resident preferences, and resident routine activities, and goal setting were not completed.	F0273	It is the policy of Miller's Merry Manor of Logansport that the facility conducts a comprehensive assessment of a resident within 14 calendar days after admission. Resident #4's MDS was completed. The care plan is current and reflects resident's plan of care. All admission/readmission MDS's have been reviewed to ensure compliance. Any resident admitted to the facility has the potential to be affected by this deficient practice. To ensure that all new admissions/readmissions have their comprehensive assessment completed within 14 days of admission, an in-service covering the MDS policy and procedure (attachment #1), was conducted on 06/12/2012 by the Clinical Assessment Director with the Health Care Plan Team. This system is monitored through the use of the Quality Assurance Tool: RAI Process/MDS review (attachment #2) completed by the Director of Nursing and/or her	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with RN #8 on 05/22/12 at 1:50 P.M., indicated she was waiting on social services department to complete the portion of the assessment "that was their part." She indicated she would "get right on that." There was no other reason given for the incomplete MDS assessment. On 05/22/12 at 9:00 A.M., the Director of Nursing presented a completed initial MDS assessment for Resident #4, which had been signed as complete by RN #8 on 05/22/12. 3.1-31(d)(1)		designee. The review will be completed monthly for 3 months and quarterly thereafter. Any identified issues will be logged on the Quality Assurance Summary Log (attachment #3). The log will be reviewed by the Quality Assurance Committee on a monthly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F0274	It is the policy of Miller's Merry Manor of Logansport that the facility conducts a comprehensive assessment of a resident within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition. Resident #109's significant change assessment was completed. The care plan is current and reflects resident's plan of care. All significant change MDS's have been reviewed to ensure compliance. All residents have the potential to be affected by this deficient practice. To ensure that any resident who has had a significant change in physical or mental condition has a comprehensive assessment done within 14 days after the facility has determined that there has	06/22/2012

Based on observation, record review and interview, the facility failed to ensure a comprehensive Minimum Data Set (MDS) assessment was completed promptly for 1 of 24 residents with a significant decline in a sample of 24. (Resident #109)

Findings include:

During the initial tour of the facility, conducted on 05/21/12 between 11:50 A.M. - 12:23 P.M., LPN #9 indicated Resident #109 had been experiencing a decline in condition. She indicated the resident was currently propelled by staff in her wheelchair, required feeding assistance, was less alert, newly evident garbled speech, was incontinent of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bladder, had recently had diet changes, and was working with therapies. At this time, the resident was observed seated in a recliner sleeping in her room. On 05/22/12 at 1:50 P.M., Resident #109 was observed in the therapy room. The resident was holding her head with her hands, was coughing, and was not responding to therapists who were talking with her at the time. A greenish bruise was noted on the right side of her forehead and face. On 05/23/12 at 9:30 A.M., CNAs #10 and #11 were observed toileting and transferring Resident #109 in her room. The resident required extensive assistance and cueing and barely supported any of her weight to complete a pivot transfer from the wheelchair to the toilet, back to the wheelchair, and then into her recliner. CNA #11 indicated the resident had "taken a tumble a few weeks ago" when asked about the bruising on the resident's face. During the process some of the resident's speech was garbled but she did keep repeating "I can't walk" when receiving instructions for the transfers. The electronic clinical record for Resident #109 was reviewed on 05/23/12 at 9:47 A.M. The MDS section of the record indicated a significant change MDS		been a significant change, an in-service covering the MDS policy and procedure (attachment #1) was conducted on 06/12/2012 by the Clinical Assessment Director with the Health Care Plan Team. This system is monitored through the use of the Quality Assurance Tool: RAI Process/MDS review (attachment #2) completed by the Director of Nursing and/or her designee. The review will be completed monthly for 3 months and quarterly thereafter. Any identified issues will be logged on the Quality Assurance Summary Log (attachment #3). The log will be reviewed by the Quality Assurance Committee on a monthly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment was pending with a date of 05/10/12. Review of the significant change MDS assessment indicated almost all of the assessment had been completed but the transferring, ambulation and mobility, and eating needs section indicated the resident required only limited assistance of 1 staff member. In addition, the assessment did not reflect the resident current therapy participation. Finally, the assessment was not signed as complete. Interview with RN #12, the MDS coordinator, on 05/23/12 at 2:45 P.M., indicated the assessment had not yet been completed nor transmitted even though the last date of reference for the assessment was 05/10/12. 3.1-31(d)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interviews, the facility failed to ensure there were adequate indications for use and adequate monitoring of medical symptoms of a psychotropic medication for 1 of 11 residents reviewed for psychotropic medication in a sample of 24. (Resident #104) In addition, the facility failed to ensure non-pharmaceutical measures were attempted prior to giving an antipsychotic and/or antianxiety medication for 2 of 11 residents reviewed for psychotropic	F0329	It is the policy of Miller's Merry Manor of Logansport that each resident's drug regimen be free from unnecessary drugs. Resident #104's antipsychotic medication use has been reviewed with her psychiatric services team and determined to be medically necessary. The resident's diagnoses have been updated to include depressive disorder, anxiety disorder, psychosis, and senile dementia. This resident has suffered no adverse effects from medication administration	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications in a sample of 24. (Resident #23 and 104). Finding includes: 1. During the initial tour of the facility, conducted on 05/21/12 between 11:50 A.M. - 12:23 P.M., LPN #9 indicated Resident #104 exhibited pacing, agitation behaviors and received the antipsychotic medications of Thorazine, Haldol, Clonazepam, and the antidepressant, Celexa. The resident was observed in the dining room during the initial tour seated in a chair waiting for the noon meal to arrive. The resident was noted to get up several times and was easily redirected back to her chair. Resident #104 was observed on 05/22/12 at 2:00 P.M. and on 05/23/12 at 1:30 P.M., ambulating around the unit. The resident was noted to want to follow staff around but was calm and did not have a distressed facial expression. The clinical record for Resident #104 was reviewed on 05/22/12 at 2:00 P.M. The resident was admitted to the facility on 09/21/11 with diagnoses including, but not limited to, dementia with behavioral disturbances, ischemia, hypertension, and blindness. Physician's orders indicated the resident, at the time of her admission on		per physician orders. Non-pharmaceutical interventions have been reviewed for residents #104 and #23. The PRN medications for both residents have been discontinued. Neither resident suffered adverse effects from medication administration per physician orders. Any resident receiving a psychotropic medication has the potential to be affected by this deficient practice. To ensure that psychotropic medications being used are appropriate to treat identified behaviors and diagnosis; monthly medication reviews are completed by the contracted Consultant Pharmacist. A review of psychotropic medications was completed by the Consultant Pharmacist on 06/06/2012. In addition, a monthly medication/behavior review is completed by members of the interdisciplinary team. During these meetings all areas related to the use of psychotropic medications are reviewed, including updating of the care plan, appropriate indications for use, and the need for a gradual dose reduction when applicable. Additionally, all licensed staff will be in-serviced on the Psychotropic Medication Use policy and procedure by 06/22/2012 (attachment #4). This system is monitored through the use of the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	09/21/11, received the antipsychotic medication, Risperdal .25 milligrams at bedtime and .5 milligram during the day. The behavior tracking indicated the resident was being monitored for argumentative behavior with the staff. The resident did not exhibit behaviors until December 2011 when she became anxious with her pacing. On 12/14/11, the physician increased the resident's Risperdal to .5 milligrams twice a day. Behavior tracking records and nursing progress notes indicated the resident continued to exhibit anxious behaviors and on 12/23/11, the physician discontinued the Risperdal and ordered the antipsychotic medication, Abilify, to be given. On 12/28/12, the physician added the antianxiety medication, Ativan, to be given every 8 hours as needed. Nursing progress notes from 12/28/11 - 01/02/12, indicated there was only one note indicating the need to medicate the resident with the Ativan medication. A note on 12/28/11 at 17:00 (5:00 P.M.), indicated the resident had "increased anxiety." There was no other description of the resident's "anxiety" documented in the note. The medication was effective for 1 hour and then the resident's behaviors returned and staff redirection was not effective. The note did not indicate what measures had been		Assurance Tool: Psychopharmacological Medication Review (attachment #5), completed by the Social Service Director and/or her designee. The review will be completed monthly for the next 4 months and quarterly thereafter. Any identified issues will be logged on the Quality Assurance Summary Log (attachment #3). The log will be reviewed by the Quality Assurance Committee on a monthly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attempted to address the resident's increased anxiety prior to administering the medication, Ativan. The Medication Administration Record (MAR) for December 2011 and January 2012 indicated the resident received the Ativan medication 7 times from December 28 2011 - December 31, 2011, and 5 times from January 01, 2012 - January 2, 2012. On 01/02/12 the resident was transferred from the facility to an inpatient psychiatric facility. The resident returned to the facility on 01/20/12. The resident was receiving the antipsychotic medications, Clonazepam .5 mgs and Fazaclo 25 milligrams once a day, and the antidepressant medication, Lexapro 20 mg once a day. In addition, physician's orders indicated the resident was scheduled for ECT (electroconvulsive therapy) treatments. Nursing progress notes, from 01/20/12 - 01/23/12 indicated the resident had an ECT treatment on 01/23/12. There were no notes indicating any problems with the resident's behavior. Behavior monitoring forms, indicated the resident was being monitored for "anger at staff, can be argumentative related to care interventions." The resident was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documented as having these behaviors on the evening of 01/20/12 and throughout the nights on 01/20/12, 01/21/12, 01/22/12 and 01/23/12. It was unclear if the behavior management interventions were effective during the documented times the medication was administered as staff initials were documented instead of the corresponding abbreviation for drug effectiveness. A nursing progress note, on 01/24/12 at 10:43 A.M. indicated the following: "Update: Resident has been experiencing hallucinations, seeing things/picking at things in the air. She has had a very unsteady gait and has been very lethargic. She will go to sleep at approx [approximately] 4:00 A.M. and sleep through the day, not very easy to arouse. Vital signs are stable. Her last ECT treatment was 01/23/12. Current psych meds [medications] given to physician." (sic) Other than the note, there was no documentation about hallucinations, unsteady gait, or lethargy. Interview with LPN #9 on 05/24/12 at 12:20 P.M., indicated the night shift had reported the hallucinations verbally to her at shift report. The resident had been up all night until approximately 4:00 A.M. and had been sleepy and lethargic for her on the day shift. She indicated since the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had never displayed hallucination type behavior previously she notified the physician. She indicated she had not observed these behaviors but the night shift staff had and had reported them to her. A physician's order was received on 01/24/12 at 12:45 P.M., to discontinue the A.M. dose of the Clonazepam and start administering the antipsychotic medication, Haldol .5 mg three times a day. Interview with LPN #9, on 05/24/12 at 12:20 P.M., indicated no medical issues had been investigated such as a possible urinary tract infection or an unwanted side effect of the ECT (electroconvulsive therapy) treatments for a possible cause of the resident's behaviors. The behavior tracking for the months of April and May 2012 indicated the facility was tracking anger at staff and anxiousness exhibited by pacing, but not hallucinations. Interview with the social service director, Employee #15, on 05/24/12 at 12:20 P.M., indicated the facility had tracked hallucinations from the time of the Haldol order through February 2012 but had stopped tracking the behavior because the resident had never exhibited the behavior again.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finally, the psychiatrist who had ordered the Fazaclo, Clonazepam, and Lexapro indicated all three medications were to be administered for dementia with delusional behaviors. The facility indicated they were not currently monitoring the resident for delusional behaviors. In addition, the side effects monitoring form, located on the MARs indicated although the nurse reported to the physician on 01/24/12 that the resident was experiencing lethargy and an unsteady gait, no side effects was documented on the MAR for 01/23/12 or 01/24/12. 2. Resident #23's clinical record was reviewed on 5/21/12 at 3:00 P.M.. The record indicated the resident had diagnoses including, but not limited to, dementia with delusions/behavior disturbances, and Alzheimer's disease. Resident #23's current medication orders from 4/23/12 included, but were not limited to, Haloperidol, 75 milligrams (mg) given intramuscularly (IM) every 14 days for dementia with behavior disturbances; Haloperidol 5 mg IM every 6 hours as needed (PRN) for increased agitation/anxiety. The resident's medication administration record (MAR) for April 2012 indicated on 4/30/12 at 11:00 A.M. the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	received Haloperidol 5 mg IM PRN. The back of the MAR indicated the reason for giving the resident the Haloperidol 5 mg IM was increased anxiety. The April 2012 MAR contains an entry for PRN agitation/anxiety protocol to be followed before administration of PRN Haloperidol. The entry indicated "1. Address physical needs; 2. Change environment. 3. Redirect thoughts. 4. All of the above. Results: I= ineffective; E= effective" The space for staff entry was blank for 4/30/12. The resident's progress notes indicated no entries for 4/30/12. An interview with LPN #5 on 5/22/12 at 2:00 P.M. indicated the nurse who administered the Haloperidol 5 mg PRN on 4/30/12 should have documented the incident on the progress notes. An interview with the Social Service Director (SSD) on 5/24/12 at 2:30 P.M., indicated a health care plan was updated on 5/21/12 to add use of Haloperidol PRN. The SSD indicated she started the health care plan when she realized the resident did not have a health care plan to address Haloperidol PRN usage before. The health care plan dated 5/21/12 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for "psychotropic drug use/mood state: Resident has order for PRN Haldol to be given every 6 hours as needed for increased agitation/anxiety." The interventions included: "Administer medication if interventions are ineffective; assess for unmet needs i.e.. toilet, pain, hunger, etc; play soothing music in background; reposition resident; avoid over stimulation." An interview with the Director of Nursing (DN) on 5/23/12 at 3:30 P.M., indicated the facility policy on psychotropic medication use did not include PRN medication administration. 3.1-48(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interviews, and record review, the facility failed to ensure 2 of 4 dietary staff handled food and/or ice in a sanitary manner. This potentially affected 120 of 121 residents in the facility who consumed food and/or ice water. Finding includes: During the dietary sanitation tour of the facility, conducted on 05/21/12 from 10:15 A.M. - 10:40 A.M., Dietary aide, Employee #13 was observed buttering bread. She was noted to have donned a pair of gloves, then touched the outside of bread loaf packages, the outside of the large plastic container of butter, the handle of a small spatula she was using to spread the butter, and was then touching the bread with both of her gloved hands. During the observation of the noon meal service, conducted on 05/21/12 at 11:20 A.M., Dietary aide, Employee #14 was observed pouring ice into glasses. The	F0371	It is the policy of Miller's Merry Manor of Logansport to procure, store, prepare, distribute, and serve food under sanitary conditions. The alleged deficient practice was corrected immediately following identification. Employees #13 and #14 were immediately in-serviced on the sanitary handling of food and/or ice (attachment #6). All residents have the potential to be affected by this deficient practice. To ensure the procurement, storage, preparation, distribution, and service of food under sanitary conditions, all dietary staff will be re-educated on the corresponding policies and procedures by 06/22/12 (attachments #6 & #7). The Dietary Manager and/or her designee will audit the alleged deficient practice weekly for 90 days and monthly thereafter using the Quality Assurance Tool: Dietary Food Safety Sanitation Checklist (attachment #8). Any identified issues will be logged on the Quality Assurance Summary Log (attachment #3). The log will be reviewed by the Quality Assurance Committee on a	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	employee was noted to have donned a pair of gloves, had a large scoop he was dipping into the ice machine and a tray of glasses. On one occasion some of the ice fell on the floor. The employee was noted to pick up the ice off of the floor with his gloved hand, throw the ice away, and then without changing his gloves continued to fill glasses with ice cubes. He was noted to be guiding the ice into the cups with his left hand and also holding ice in the scoop with his left hand touching the ice as he carried it from the ice machine bin to the cart on which the glasses were arranged. Interview on 05/22/12 at 11:30 A.M., with the Food Service Supervisor, employee #15 regarding the concern indicated Employee #14 was new and that she would inservice both employees on their technique for handling food and/or ice. Review of the facility policy and procedure, provided on 05/23/12 at 9:00 A.M., by the Director of Nursing and indicated as the current policy, titled, "Food Preparation, Food Handling, and Service", dated to expire on 05/22/12, indicated the following: "...Proper utensils are used when directly handling foods to avoid manual contact with prepared foods...Glove use should be		monthly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited. If used, a single-use glove will be used for only one task while working with ready to eat food or raw animal food. This glove will be used for no other purpose and discarded when damaged, soiled, or when interruptions occur in the process." 3.1-21(i)(3)			